BOTULINUM AND DERMAL FILLER NEW CLIENT HISTORY FORM

New River Family Wellness, PLLC
420 East Second Street, West Jefferson, NC 28694

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Medical History

List of medications and/or vitamins that you are taking: _____

_____

_____

Allergies: _____ Are you taking antibiotics at this time? _____

Primary Physician's Name & Number: _____

Have you ever been diagnosed with or treated for any of the following (please mark yes or no to all)?

Yes No	Cancer	Yes No	Hepatitis	Yes No	Multiple Sclerosis
Yes No	High Blood Pressure	Yes No	Heart Conditions	Yes No	Lupus
Yes No	Arthritis	Yes No	Thyroid Imbalance	Yes No	Keloid Formation
Yes No	HIV/AIDS	Yes No	Any active infection	Yes No	Autoimmune Disease
Yes No	Skin Disease	Yes No	Myasthenia Gravis	Yes No	Parkinson's Disease
Yes No	Seizure Disorder	Yes No	Muscle Weakness	Yes No	Neurological Disorders
Yes No	Hormone Imbalance	Yes No	History of Cold Sores	Yes No	Numbness
Yes No	Blood Clotting Disorder	Yes No	Hepatitis	Yes No	Lambert-Eaton Syndrome
Yes No	Allergy to beef or dairy products	Yes No	Hypersensitivity to medications	Yes No	Eye disease or vision problems
Yes No	Stroke or Mini-stroke (CVA or TIA)	Yes No	Sensitivity/Allergy to Lidocaine	Yes No	Amyotrophic Lateral Sclerosis

List and/or explain other medical conditions not listed above: _____

_____

Are you currently taking any of the following (please mark yes or no to all)?

Yes No	Aspirin	Yes No	Fish Oil	Yes No	Ginger
Yes No	Blood thinners	Yes No	Omega 3 fatty acids	Yes No	Cayenne
Yes No	Hormones	Yes No	Ginkgo biloba	Yes No	Licorice
Yes No	Vitamin E	Yes No	Garlic	Yes No	Flax seed oil
Yes No	Mood altering medication	Yes No	Anti-depression medication	Yes No	COQ10

Previous Hospitalizations/Operations:_____

_____

Have you had plastic surgery or other surgery to your face/neck area and when:_____

_____

WOMEN: Are you pregnant, trying to get pregnant or lactating?_____

Botulinum Toxin History

Have you had botulinum injections before? _____ Last treatment:_____

What areas? _____ Were you happy?_____

If not, please explain:_____

Have you ever had eyelid/eyebrow droop after botulinum?_____

Do your eyelids droop without sleep?_____

Do your eyelids feel extra heavy when you don't get enough sleep?_____

Do you show a lot of upper eye lid when eyes are open?_____

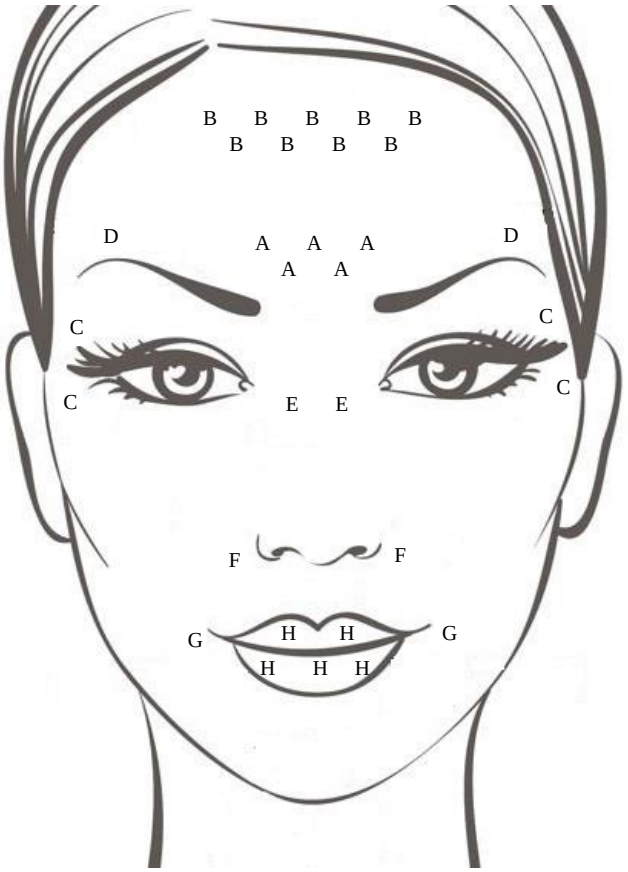
Dermal Filler History

Have you had temporary or permanent dermal filler injections before? _____ Last treatment: _____

What areas? _____ Were you happy?_____

If not, please explain: _____

Please indicate those areas of concern for you in the picture below:



Botulinum Toxin Treatment Areas and Estimated Units

A.	Frown Lines	25-50 units
B.	Horizontal Forehead Lines	10-16 units
C.	Crow's Feet	30-40 units
D.	Eyebrow Lift	10-14 units
E.	Bunny Lines	10-14 units

Dermal Filler Treatment Areas and Estimated Vials

F.	Nasolabial Fold	1-2 vials
G.	Marionette Lines	1-2 vials
H.	Lip Enhancement	1-2 vials

Current Pricing (subject to change)

Botulinum Toxin $8 per unit
Dermal Filler $450 per vial

Please list any other concerns or goals for your botulinum or dermal filler procedure:_____

_____

_____

_____

_____

_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Patient Signature Date